

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

### 1. PLACE OF DEATH:

County Washington  
City or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1.5 years  
Hospital, institution, or street address where death occurred:  
S. main St.  
How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. S. main St.  
(If rural, give LOCATION)  
2(a) If veteran, name war none

### 3. (a) FULL NAME

Laura Virginia Babbington

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife Single  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) September - 7 - 1867  
8. AGE: Years 78 Months 10 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Man Harmon Ind. Co. Md.  
(Town, county, and state)

10. Usual occupation none

### 11. Industry or business

FATHER 12. Name Joseph Babbington  
13. Birthplace Ind. Co. Md.  
MOTHER 14. Maiden name Caroline Wise  
15. Birthplace Ind. Co. Md.

16. Informant Edward Babbington  
Address Boonsboro Md.

17. Burial Date thereof July 15, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Lutheran Cemetery  
Location Middletown Md.

18. Funeral director Levi J. Best & Sons  
Address Boonsboro Md.

19. July 15 19 46 John L. Best  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July - 13 - 1946 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 - 1946 to July 13 - 1946  
and that I last saw him alive on July 13 - 1946

Immediate cause of death Coronary Thrombosis

DUE TO Paralysis Agitans

DUE TO \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE John L. Best M.D.  
M. D. or other

Address Boonsboro Md. Date signed 7/14/46

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Trade

22

07319

RECEIVED  
JUL 17 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. B.B.Kneisley 159

07320 302  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Years  
 Hospital, institution, or street address where death occurred:  
Maple Ave  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Maple Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... None

## 3. (a) FULL NAME

Mrs. Thalia Virginia Ball

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Bernard M.  
 7. Birth date of deceased (mo., day, yr.) October 15 1859  
 8. AGE: Years 86 Months 8 Days 22 It less than one day  
 6. (c) If alive, give age... years

9. Birthplace Benevola Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Dr. Robert H.E. Boetler  
 13. Birthplace Brownsville Md.  
 14. Maiden name Rebecca Hammond  
 15. Birthplace Brownsville Md.

16. Informant Bernard R. Ball  
 Address Funkstown Md.  
 17. Burial Date thereof 7/9/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Funkstown Cemetery  
 Location Funkstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 9 1946  
 (Date rec'd by registrar) Registrar Chas H Bowers

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1946 19... at 11 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 18, 1946 19... to July 7, 1946  
 and that I last saw her alive on July 6, 1946 19...  
 Immediate cause of death...  
Chronic nephritis  
 DURATION  
Indef.  
 Due to...  
 Due to...  
 Other conditions General arteriosclerosis Indef.  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...  
 Where did injury occur? (City or town) (County) (State)  
 injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE B.B. Kneisley M. D. or other  
 Address 148 W. Washington St. Date signed 7/8/46

RECEIVED

JUL 11 1946

BUREAU VI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(128)

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

## 1. PLACE OF DEATH:

County..... WashingtonCity or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 2 weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution?..... 2 weeks

## 3. (a) FULL NAME

Edna Mae Benner

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... WashingtonCity or town..... Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

4. Sex..... Female5. Color or race..... White6. (a) Single, married, widowed, or divorced..... Widowed6. (b) Name of husband or wife..... Earl Benner

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 24, 19058. AGE: Years..... 41 Months..... 1 Days..... 29  
..... hrs. .... min.9. Birthplace..... Sharpsburg-Wash.-Maryland  
(Town, county, and state)10. Usual occupation..... Home Duties

11. Industry or business

12. Name..... John Tucker13. Birthplace..... Sharpsburg, Md14. Maiden name..... Lydia Ebersole15. Birthplace..... Sharpsburg, Md16. Informant..... Miss Pearl BennerAddress..... Sharpsburg, Md17. Burial Date thereof..... July 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... NationalLocation..... Sharpsburg, Md18. Funeral director..... R. I. EarnshawAddress..... Keadysville, Md.19. July 24 :19 46 Chauff Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 23 19 46 at 7:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19 45 to July 22 19 46and that I last saw him/her alive on July 22 19 46Immediate cause of death..... Acute pancreatitis DURATION..... 3 daysDue to..... Acute cholecystitis DURATION..... 3 or 4 daysDue to..... And (hypertension) DURATION..... ?Other conditions..... Essential hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Walter H. Shady M.D. or otherAddress..... Sharpsburg, Md Date signed..... 7/23/46

RECEIVED

JUL 26 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
Washington Co. Hoops  
 How long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2204 Gay St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Frank Benjamin Boltner

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Emma Pittman

Sept 22, 1873 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 72 Months 9 Days 10 If less than one day..... hrs. .... min.

9. Birthplace Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Daniel Bitner

13. Birthplace Franklin Co. Pa.

14. Maiden name Nellie Grobwell

15. Birthplace Franklin Co. Pa.

16. Informant Mrs. G. D. Staley

Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 7-5-46  
 (month) (day) (year)

Cemetery or crematorium Cedar Hill

Location Greencastle, Pa.

18. Funeral director Frank W. Zetter

Address Greencastle, Pa.

19. July 2 1946 Registrar Frank W. Zetter

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1946 to July 2 1946

and that last saw him alive on July 1 1946

Immediate cause of death.....

DURATION

Due to Ch. Myocarditis

Due to arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. W. Zetter

M. D. or other

Address Hagerstown, Md. Date signed 7/4/46



RECEIVED

JUL 5 1946

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Evidence for change of age of deceased is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 300

FILM No. 106 AUG 21 1946

### 1. PLACE OF DEATH:

County... Washington County

City or town... Sharpsburg Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, institution, or street address where death occurred:

Sharpsburg Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town... Sharpsburg Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main St. Sharpsburg, Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Helen Eliza Blackford

### 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

B.(b) Name of husband or wife... Single

7. Birth date of deceased (mo., day, yr.)

Oct. 22 1879

8. AGE: Years Months Days If less than one day

67 66 8 26 hrs. min.

9. Birthplace... Sharpsburg Md.  
(Town, county, and state)10. Usual occupation... Housewife  
Home

11. Industry or business

FATHER 12. Name... William Franklin Blackford

13. Birthplace... Sharpsburg Md

MOTHER 14. Maiden name... Emma Grove Blackford

15. Birthplace... Baltimore, Md.

16. Informant... Miss Pauline Blackford

Address... Sharpsburg Md.

17. Burial Date thereof July 21 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mountain View Cemetery

Location... Sharpsburg, Md.

18. Funeral director... Edith V. Leaf

Address... #7 Church St. Williamsport, Md

19. July 21 1946 Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1946 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23, 1946 to July 18, 1946

and that I last saw her alive on July 15, 1946

Immediate cause of death... Carcinoma

DURATION

?

Primary Carcinoma of Ovary

Due to... Duration: 18 months

Cause of...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... No operation performed.

Autopsy results... No autopsy performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... Henry M.D.

Address... Sharpsburg, Md.

Date signed July 19, 1946

RECEIVED

AUG 3 1946

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60-2)

## CERTIFICATE OF DEATH

07323

219

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution: Washington County Hospital  
 Stay in hospital or inst. (yrs., or mos., or days) 2 days  
 Stay in this community (yrs., or mos., or days) \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. 1021 Columbia Rd.  
 (If rural give LOCATION)  
 2(a) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

Baby Girl Bryan

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

7-15-46

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace Hagerstown, Wash. Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Norman Clifford Bryan

13. Birthplace

MOTHER

14. Maiden name Dorothy Blevens15. Birthplace West Newton, Pa.16. Informant Dorothy B. BryanAddress 1021 Columbia Rd, Hagerstown, Md.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof 7-17-46  
(month) (day) (year)

Cemetery or crematory

Location Washington County Hospital

18. Funeral director

Address

19. Aug 20 19 46 Blair H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

7-1719 46, el 6<sup>15</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-1519 46, to 7-1719 46,and that I last saw her alive on 7-1719 46.

Immediate cause of death

Respiratory failure

DURATION

Due to Pulmonary atelectasis

Due to

Other conditions Cerebral hemorrhage

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Pulmonary atelectasisOf autopsy Cerebral hemorrhage

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elizabeth L. Linton M.D.

M. D. or other

Address Hagerstown, Md. Date signed 8-18-46

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 22 1946  
BUREAU V.B.

07324

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 3 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 908 Summit Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... ---

## 3. (a) FULL NAME

Mrs. Alice Virginia Byers

## 3. (b) Social Security Number

-----

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Daniel A. Byers

7. Birth date of deceased (mo., day, yr.) August 12, 1878 6. (c) If alive, give age... years

8. AGE: Years 67 Months 10 Days 26 If less than one day  
 --- hrs. --- min.

9. Birthplace... Mercersburg Franklin Co., Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. FATHER James Hospelhorn13. BIRTHPLACE Mercersburg Pa.14. MOTHER Alice Virginia Mowen15. BIRTHPLACE Mercersburg Pa.16. Informant Mrs. William HetzerAddress Erie Penna.

17. Burial Date thereof 7/10/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview CemeteryLocation Mercersburg Penna.18. Funeral director Andrew K. CoffmanAddress Hagerstown Maryland

19. July 10 1946 Registrar Shasth Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 46, at 6:15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
3-8 19 41, to 7-8 19 46  
 and that I last saw her alive on 7-8 19 46.

Immediate cause of death acute pulmonary edema DURATION 4 hours

Due to Hypertension - arteriosclerotic Heart Disease & aur. fibrillation 3 years  
(at least 5)

Due to Coronary thrombosis 15 days

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results... Date of op. ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hornbaker M.D.Address 154 W. Washington St., Hagerstown, Md. Date signed 7-9-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07325

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Mos

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 Mos

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 820 Guilford Ave

(If rural, give LOCATION)

None2. (a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. Myrtle Louise Clark

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Charles L.6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) June 16 18868. AGE: Years 60 Months 0 Days 24 hrs. min.9. Birthplace Edenville Franklin Co. Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Martin Roof13. Birthplace Edenville Pa.14. Maiden name Josephine Fogle15. Birthplace Edenville Pa.16. Informant Chester L. ClarkAddress Hagerstown Md.17. Burial Date thereof 7/12/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 12 46 Registrar Black/Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 10 1946 19 46 at 3 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 31 19 46 to July 10 19 46and that I last saw him alive on July 10 19 46

Immediate cause of death

Carcinoma Rectum

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE H. H. Porterfield M.D.Address 136 W Washington Date signed 7/12/46

M. D. or other



RECEIVED  
JUL 15 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

07326

Reg. Diat. No. 304

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

Washington

Hagerstown

71 years

64 Randolph Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

Md.

Washing ton

Hagerstown

64 Randolph Ave.

(If rural, give LOCATION)

## 3.(a) FULL NAME

Grace May Alice Delauter

## 3.(b) Social Security Number

--

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....

12. Name.....  
 13. Birthplace.....  
 14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....

17. Burial..... Date thereof.....  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location.....

18. Funeral director.....  
 Address.....

19. July 31 19 46  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30, 19 46 at 3:00a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 30-46 19 46 and that I last saw him alive on July 30-46 19 46

Immediate cause of death.....

DURATION

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operatiuus..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

RECEIVED  
AUG 2 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on EVIDENCE is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**  
of deceased is shown on 2411 N. Charles St., Baltimore 940

FILM No. I 0 6 AUG 16 1946

# CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Washington County  
City or town Williamsport, Md. RFD #2  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 70 yrs  
Hospital, institution, or street address where death occurred:  
Williamsport, Md RFD #2 (Pinesburg)  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Williamsport Md RFD #2  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Pinesburg  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

## 3. (a) FULL NAME

Charles W. Detrow, Charles W.

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Ida M. Davis  
Deceased 6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) March 11 1873  
8. AGE: Years 72 Months 73 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Farm Labor  
11. Industry or business Farm  
12. Name John Luther Detrow  
13. Birthplace Middletown Md  
14. Maiden name Catherine Crouce  
15. Birthplace Middletown Md

16. Informant Mrs. Earl C. Shank (Foster-daughter)  
Address Williamsport Md RFD #2 (Pinesburg)  
17. Burial Date thereof Aug. 1 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rest Haven Cemetery  
Location Hagerstown, Maryland  
18. Funeral director Edith V. Leaf  
Address #7 Church St. Williamsport, Md.

19. Aug 1 19 46 Registrar Mrs E Lee McElroy Williamsport Md  
(Date registered by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28/46 19 2:15 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20/46 19 7/29/46 19 7/29/46  
and that I last saw him alive on 7/29/46 19 7/29/46  
Immediate cause of death Coronary Occlusion DURATION 5 Days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. F. Young M. D. or other 7/31/46  
Address Williamsport Md Date signed 7/31/46

RECEIVED

AUG 5 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

07328304  
Reg. Dist. No. 304

### 1. PLACE OF DEATH:

County Washington  
City or town Hancock, Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Years  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hancock, Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

John Wm Dixon

### 3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Inez Dixon

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov. 23 1870

8. AGE: Years 75 Months 7 Days 22 If less than one day.....hrs. ....min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Self Employed

12. Name Not Known

13. Birthplace Not Known

14. Maiden name Not Known

15. Birthplace Not Known

16. Informant Robert B. Dixon

Address Cumberland, Md. R.F.D. # 3

17. Burial July 17 1946  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Stone Bridge Dunkard Cemetery

Location Near Hancock, Md.

18. Funeral director Snyder- Rowland

Address Hancock, Md.

19. 7/17/46  
(Date rec'd by registrar)

Registrar J. A. Heller

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1946 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....DURATION

Chr. Myocarditis 6 mo.

Due to Prostatitis by pathophys 1 mo.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE J. R. Wells July 15/46

Address Hagerstown, Md. Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 19 1946  
BUREAU F. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 years

Hospital, institution, or street address where death occurred:

Hillcrest Nursing Home

How long in hospital or institution? 7 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Wash.

City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 327 N. Cannon Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war -----

## 3. (a) FULL NAME

Nannie Fahrney

## 3. (b) Social Security Number

----

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 5, 1861 6. (c) If alive, give age years

8. AGE: Years 84 Months 7 Days 3 If less than one day hrs. min.

9. Birthplace Wash. Co., Md.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name William Fahrney

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Emma Benner

Address Hagerstown, Md.

17. Burial Date thereof 7-10-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Hagerstown, Md.

Location

18. Funeral director Scott F. Minnich &amp; Son

Address Hagerstown, Md.

19. July 10 1946 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1946 7:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

from 1-46 19 to July 8-46

and that I last saw him alive on July 8-46 19

Immediate cause of death

## DURATION

Cerebral Hemorrhage 10 days

Due to

Due to cerebral sclerosis 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed

RECEIVED  
JUL 12 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1912)

07330

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Steel Crest Convalescent Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pennsylvania County... Franklin

City or town... Waynesboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. 241 East main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William J. Fleagel

## 3. (b) Social Security Number

173-09-5117

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Roberta Berlin

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1879

6. (c) If alive, give age 78 years

8. AGE: Years 67 Months 6 Days 11

If less than one day  
hrs. min.

9. Birthplace... Thurmont Md.

(Town, county, and state)

10. Usual occupation... Cemetery Caretaker

11. Industry or business

12. Name... Geo. J. Fleagel

13. Birthplace... Md.

14. Maiden name... Francetta Dotterer

15. Birthplace... Md.

16. Informant... Mrs. Roberta J. Fleagel

Address... Waynesboro Pa.

17. Burial, cremation, or removal, Which? Burial Date thereof July 25, 1946

Cemetery or crematory... Bunsen Hill

Location... Waynesboro Pa.

18. Funeral director... Walter U. Grove

Address... Waynesboro Pa.

19. July 24, 1946 Registrar

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 22, 1946, at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19, 46, to July 22, 1946

and that I last saw him alive on July 28, 1946

Immediate cause of death... Congestive heart failure

DURATION

6 mo

Due to... Sudden arteriosclerotic heart and kidney disease

Due to

Other conditions... Pulmonary and aortic

systemic hypertension

(Include pregnancy within 3 months of death)

Major findings of operations... systolic murmurs

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... David P. Ellis M.D.

Address... Date signed 7/24/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 26 1945  
BUREAU V S.

Dr. L. E. Jan. 23  
M  
MARGIN RESERVED FOR BINDING  
VS A15 9-45-15  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.  
T

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

07331

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
City or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
n. main st.  
How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. n. main st.  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

## 3. (a) FULL NAME

Olive Anna Mary Flook

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
8.(b) Name of husband or wife J. Calvin Flook  
8.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) July, 28 - 1867  
8. AGE: Years 78 Months 11 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace near Boonsboro Wash. Co. md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home

12. Name John E. Bowman

13. Birthplace Benevola Wash. Co. md.

14. Maiden name Margaret Stoffer

15. Birthplace Beaver Creek Wash. Co. md.

16. Informant J. Calvin Flook

Address Boonsboro md.

17. Buried Date thereof July 16, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro md.

18. Funeral director Wm. J. Bart & Son

Address Boonsboro md.

19. July 15, 1946 John W. Bart

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 46 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 19 46 to July 12 19 46

and that I last saw him alive on July 12 19 46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Influenza Pectoris

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. W. Lelley M. D. M. D. or other

Address Boonsboro Date signed 7/13/46

RECEIVED  
JUL 17 1946  
BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:  
County... Washington  
City or town... Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Lakin Ave.  
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... Maryland County... Washington  
City or town... Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... Lakin Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war... none

3.(a) FULL NAME  
George H. Ford

3.(b) Social Security Number  
none

4. Sex... Male  
5. Color or race... white  
6.(a) Single, married, widowed, or divorced... Married  
8.(b) Name of husband or wife... Blanche L. Ford  
8.(c) If alive, give age... years  
7. Birth date of deceased (mo., day, yr.)... August 29, 1871  
8. AGE: Years... 74 Months... 10 Days... 23 If less than one day... hrs. min.

9. Birthplace... Boonsboro Wash. Co. Md.  
(Town, county, and state)  
10. Usual occupation... Retired Farmer  
11. Industry or business... Own Farm

12. Name... James P. Ford  
13. Birthplace... Wash. Co. Md.  
14. Maiden name... Malinda C. Young  
15. Birthplace... Wash. Co. Md.

16. Informant... Mrs. Blanche L. Ford  
Address... Boonsboro Md.

17. Burial... (Burial, cremation, or removal, which?) Date thereof... July 24, 1946  
(month) (day) (year)  
Cemetery or crematory... Boonsboro Cemetery  
Location... Boonsboro Md.

18. Funeral director... Wm. J. East & Son  
Address... Boonsboro Md.

19. July 24, 1946 John H. Baxt  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... July 22, 1946, at 7:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 21, 1946, to July 22, 1946,  
and that I last saw him alive on July 22, 1946.

Immediate cause of death... Excess of Stomach  
DURATION... 8 hrs

Due to...  
Due to...  
Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...  
Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE... J. Hubert Wade, M.D.  
M. D. or other  
Address... Boonsboro Md. Date signed... 7/23/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade.

07332

25



RECEIVED  
JUL 29 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07333

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

745 Spruce Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 745 Spruce Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Martin Van Buren Green

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Maggie Green

## 7. Birth date of deceased (mo., day, yr.)

November 7, 1869

## 6. (c) If alive, give age years

## 8. AGE:

Years

76

Months

7

Days

27

If less than one day

hrs.

min.

## 9. Birthplace

Hagerstown, Wash. Co. Md.

(Town, county, and state)

## 10. Usual occupation

Retired Brakeman

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Martin Green

## 13. Birthplace

Funkstown, Maryland

## 14. Maiden name

Susan R. Smith

## 15. Birthplace

Germany

## 16. Informant

Mrs. Birdie Bowers

## Address

Hagerstown, Maryland

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

7-8-46  
(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Hagerstown, Maryland

## 18. Funeral director

C. M. Suter & Sons

## Address

Hagerstown, Maryland

## 19.

July 5, 1946  
(Date read by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 4

19

46 at 9:00 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15, 1946 to July 4, 1946  
and that I last saw him alive on May 25, 1946

## Immediate cause of death

Hypertensive and Sickle Heart Disease  
by extension

## DURATION

## Due to

## Due to

## Other conditions

Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Phyllis M. Suter, MD  
1594 Washington St  
Address

M. D. or other

Date signed 7/5/46

RECEIVED  
JUL 8 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

## CERTIFICATE OF DEATH

Reg. Dist. No. 07334 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1016 Hamilton Blvd.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

William S. Green

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Bessie Green

B. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

August 9, 1860

## 8. AGE:

85

Years

11

Months

Days

5

If less than one day

hrs.

min.

## 9. Birthplace

Pine Hill, N.Y.

(Town, county, and state)

## 10. Usual occupation

Retired Contractor & Builder

## 11. Industry or business

FATHER

## 12. Name

William Charles Green

## 13. Birthplace

Somersetshire, England

MOTHER

## 14. Maiden name

Mary Snyder

## 15. Birthplace

Pine Hill, N.Y.

## 16. Informant

R. Bernard Green

## Address

Hagerstown, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7-17-46

(month) (day) (year)

## Cemetery or crematory

Willtwyck Cemetery

## Location

Kingston, New York

## 18. Funeral director

C. M. Suter & Sons

## Address

Hagerstown, Maryland

## 19. Date rec'd by registrar

July 16, 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1946 19. at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 12, 1946 19. to July 14, 1946  
 and that I last saw him alive on July 14, 1946 19.

## Immediate cause of death

Mesenteric thrombosis with hemorrhage

## DURATION

3 days

## Due to

## Due to

## Other conditions

General arteriosclerosis

(Include pregnancy within 3 months of death)

Indef.

## Major findings of operations

Date of op.

Autopsy results Same as above July 14, 1946

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

B. S. Bowers

M. D.

M. D. or other

Address 148 W. Washington St. Date signed 7/15/46

RECEIVED

JUL 18 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. *MV*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

## CERTIFICATE OF DEATH

07335

304

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Route 40 Near Hancock, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pennsylvania County... Franklin

City or town... Warfordsburg Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war... World War II *★* ☒

## 3. (a) FULL NAME

Robert Quay Hann

## 3. (b) Social Security Number

209-12-9654

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife... Catherine Hann

7. Birth date of deceased (mo., day, yr.)

August 27, 1925

6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day  
21 10 26 hrs. min.

9. Birthplace... Warfordsburg, (RFD) Pennsylvania  
 (Town, county, and state)

10. Usual occupation... Discharged Marine

11. Industry or business

12. Name... Edward Hann13. Birthplace... Fulton County, Pa.14. Maiden name... Goldie Goodman15. Birthplace... Fulton County, Pa.16. Informant... Mrs. Goldie HannAddress... Warfordsburg, Pa. Rural

17. Burial Date thereof... July 25, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mays CemetaryLocation... Near Hancock18. Funeral director... Snyder RowlandAddress... Hancock, Maryland

7/25/46 J. A. Heller  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION *E.D.S.T.*2D. DATE OF DEATH... July 22 19... 46 at... 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19...

and that I last saw him... alive on... 19...

Immediate cause of death...

DURATION

Fractured cervical vertebraDue to... fractured jaw (closed)Due to... Hemorrhage & shock

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operation... No

Date of op. ....

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of... 7/22/46Where did injury occur... Bankhead Wash. Ind.  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway Route 100Injured at work? No

DEPUTY MEDICAL EXAM.

23. SIGNATURE... J. Robert Wells WASH. CO., MD.Address... Hagerstown, Md. Date signed... 7/24/46

RECEIVED

JUL 27 1946

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

07336

Reg. Dist. No. 201

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Katherine Rebecca Harsh

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

B. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 18808. AGE: Years Months Days If less than one day  
66 3 23 hrs. min.9. Birthplace Pa.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Moser  
13. Birthplace Frankfort, GermanyMOTHER 14. Maiden name Maria Traver  
15. Birthplace Chambersburg, Pa.18. Informant Charles Harsh Jr.Address Williamsport, Md.17. Burial Date thereof July 28, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress Williamsport, Md.July 28 1946 Miss Lee McElroy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 46 at 9:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26 19 46 to July 26 19 46  
and that I last saw him alive on July 26 19 46

Immediate cause of death

Cerebral Occlusion

## DURATION

48 hours

Due to

Due to myocarditis 10 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Don Lee McElroy M. D. or otherAddress Williamsport, Md. Date signed 7/27/46

RECEIVED  
JUL 31 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Washington  
City or town... Rural Hagerstown #5  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Ind. County... Washington  
City or town... Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... Hagerstown #5  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME

Blanche Irene Hastle

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced M.  
6.(b) Name of husband or wife Charles C. Hastle  
6.(c) If alive, give age 61 years  
7. Birth date of deceased (mo., day, yr.) June 19, 1898  
8. AGE: Years 48 Months 1 Days 9 If less than one day  
hrs. min.

9. Birthplace Leitersburg Ind.  
(Town, county, and state)  
10. Usual occupation House Duties  
11. Industry or business  
12. Name Chas Wm. Anderson  
13. Birthplace Leitersburg Ind.  
14. Maiden name Lula May Hastle  
15. Birthplace Leitersburg Ind.

16. Informant Mr. Chas Hastle  
Address Hagerstown Ind. #5  
17. Burial Date thereof July 31, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill  
Location Hagerstown Ind.  
18. Funeral director Walter H. Grove  
Address Waynesboro Pa.  
19. July 29, 46 Registrar  
(Date rec'd by registrar)

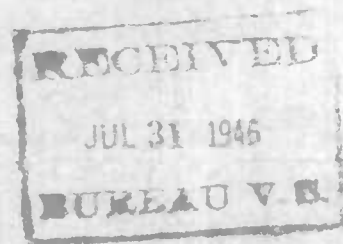
MEDICAL CERTIFICATION

20. DATE OF DEATH July 28- 46 at 7 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1- 46 to July 28- 46  
and that I last saw him alive on July 28- 46  
Immediate cause of death Carcinoma  
Due to Cervix  
Due to metastasis  
Other conditions  
(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE W. C. O'Neil M. D. or other  
Address Hagerstown Ind. Date signed 7/29/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (187)

## CERTIFICATE OF DEATH

07338

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Hours

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pennsylvania County... Franklin

City or town... Rural Greencastle Route #2 (If outside city or town limits, write RURAL and give nearest town)

Street No... Welsh Run (If rural, give LOCATION)

2.(a) If veteran, name war... None

## 3. (a) FULL NAME

David W. Hawbaker

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife... Sadie

6.(c) If alive, give age... 60... years

7. Birth date of

deceased (mo., day, yr.) July 28, 1882

8. AGE:

63

Years

Months

11

Days

21

If less than one day

... hrs. ... min.

9. Birthplace... Welsh Run Franklin Co. Pa.  
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business... Active

12. Name... David M. Hawbaker

13. Birthplace... Welsh Run Pa.

14. Maiden name... Barbara Myers

15. Birthplace... Welsh Run Pa.

16. Informant... Mrs. Sadie Hawbaker

Address... Greencastle Pa. R#2

17. Burial Date thereof... 7/23/46  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory... Myers Cemetery

Location... Near Welsh Run Pa.

18. Funeral director... Andrew K. Coffman

Address... Hagerstown Maryland

19. July 20, 1946 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION E. D. S. T.

20. DATE OF DEATH... July 19 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Perforated Ileum  
Peritonitis

DURATION

33 hrs

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations

as above July 19, 1946 Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of 7/18/46

Where did injury occur? Greencastle Franklin Pa.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Kicked by horse Injured at work? Yes

DEPUTY MEDICAL EXAM.

23. SIGNATURE

Robert Wells Hagerstown, Md.

M. D. or M.P.

Address... Date signed 7/19/46

RECEIVED  
JUL 23 1946  
BUREAU V.B.



07339

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Year

Hospital, institution, or street address where death occurred:

2025 Virginia AveHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2025 Virginia Ave

(If rural, give LOCATION)

None

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mrs. Harriett Elizabeth Hill

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Jacob W.

7. Birth date of

deceased (mo., day, yr.)

May 21 1857

6.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

8721

hrs.

min.

9. Birthplace... Elders Ridge Indiana Co. Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Robert Reeves

13. Birthplace

Elders Ridge Pa.

MOTHER

14. Maiden name

Hannah Allen

15. Birthplace

Elders Ridge Pa.

16. Informant

Miss Harriett E. Hill

Address

Pittsburg Pa.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/24/46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

July 24

19

46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946 19... at 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21 1946 to July 22 1946  
and that I last saw him/her alive on July 21 1946

Immediate cause of death

Cerebral Thrombosis

DURATION

24 hours

Due to

Arterio Sclerosis2 Years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Zimmerman  
Williamford Md

M. D. or other

Date signed 7/23/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 26 1946

BUREAU V S



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63a

## CERTIFICATE OF DEATH

Reg. Dist. No. 07340 24 304

### 1. PLACE OF DEATH:

County Washington  
City or town Hancock, Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hancock, Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

John Wesley Hill

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Axie Hill

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 2 1882

8. AGE: Years 64 Months 3 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Fulton Co., Pa.  
(Town, county, and state)

10. Usual occupation Retired Restaurant Proprieter

11. Industry or business

12. Name Nathan Hill

13. Birthplace Fulton Co., Pa.

14. Maiden name Mary Booth

15. Birthplace Fulton Co., Pa.

18. Informant Mrs. Axie Hill

Address Hancock, Md.

17. Burial Date thereof July 21 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pauls Cemetery

Location Western Pike Wash. Co.

18. Funeral director Snyder- Rowland

Address Hancock, Md.

19. 7/20/46 Registrar J. D. Heller  
(Date rec'd by registrar) 19 \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18 19 46 to 7-18 19 46 and that I last saw him alive on June 15 19 46

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Atherosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Anteapay results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Herbert R. Lohman M. D. or other \_\_\_\_\_

Address Hancock Md. Date signed 7-20-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 24 1946  
W. A. D. V. E. D. P.

122  
500  
000

COPY SENT TO <sup>Co.</sup> ~~LOCAL~~ REGISTRAR ~~DATE~~ 7/24/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

07341  
Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 9 month  
 Hospital, institution, or street address where death occurred:  
59 Elizabeth Street  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Rural Clearspring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Blairs Valley near Clearspring, Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Barbara Ellen Hornbecker

## 3. (b) Social Security Number

None

4. Sex..... Female  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Charles Melvin Hornbecker

7. Birth date of deceased (mo., day, yr.)..... March 6, 1881  
 6.(c) If alive, give age..... years

8. AGE: Years..... 65 Months..... 4 Days..... 10  
 If less than one day..... hrs. .... min.

9. Birthplace..... Franklin Co. Penna.  
 (Town, county, and state)

10. Usual occupation..... Home duties

## 11. Industry or business

FATHER 12. Name..... D. W. Blair  
 13. Birthplace..... Penna.

MOTHER 14. Maiden name..... Christina Nixon  
 15. Birthplace..... Penna.

16. Informant..... Charles Hornbecker  
 Address..... 59 Elizabeth St. Hagerstown, Md.

17. Burial..... Shanktown Cemetery  
 (Burial, cremation, or removal. Which?) Date thereof..... July 19, 1946  
 (month) (day) (year)

Cemetery or crematory..... Shanktown, Maryland.  
 Location.....

18. Funeral director..... Snyder- Rowland.  
 Address..... Clearspring, Maryland.

19. July 18, 46 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 16, 46 at..... 4:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 15, 46 to July 16, 46  
 and that I last saw her alive on July 15, 46

Immediate cause of death.....

Coronary Disease  
 Due to.....

Due to..... Hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE..... EW Smith  
 M. D. or other

Address..... Hagerstown, Md. Date signed..... 7/16/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



File as Death

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF STILLBIRTH

(159) \* Birth 9 Death 07342

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington  
City or town Hagerstown Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
Washington County Hospital  
Length of mother's stay in County  
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland  
County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 407 Elizabeth Street  
(If RURAL give LOCATION) E.D.S.T.

3. Name of child

5. Sex M

6. Twin or triplet I

4. Date of birth 7-3 1946 Hour 12 AM

7. No. of weeks pregnancy 19 1/2

FATHER OF CHILD

8. Full name Simon Peter Nose  
9. Color W 10. Age at time of this birth 57 yrs.  
11. Usual occupation Stationary Fireman

MOTHER OF CHILD

12. Full maiden name Mildred Louise Rockwell  
13. Color W 14. Age at time of this birth 38 yrs.  
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of uterine bleeding

19. Labor: (a) Complications of uterine bleeding  
two weeks prior to abortion (b) Induced? no

20. (a) Was there an operation for delivery? no (Yes or No)

(b) State all operations, if any none

(c) Did child die before operation? no

During operation? no

23. (a) Cremation (b) Date thereof 7-3-46  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory

24. (a) Funeral director

(b) Address

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes low lying placenta

(b) Maternal causes noted

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

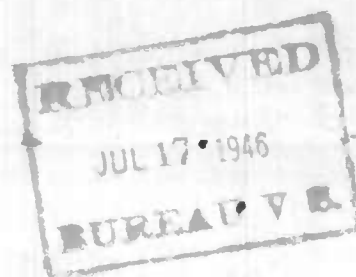
Signature L. B. Beachy, M.D.  
(Specify if M. D., midwife, or other)

Address

25. (a) July 15, 1946 (b) Black Howard  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per



File as Death

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

Birth &amp; Death

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

## 1. PLACE OF BIRTH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street address, hospital or institution:  
Washington County HospitalLength of mother's stay in County.....  
(How many years, or months, or days. SPECIFY WHICH)

## 2. USUAL RESIDENCE OF MOTHER:

State MarylandCounty WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 Elizabeth Street  
(If RURAL, give LOCATION)3. Name of child Ben5. Sex m | 6. Twin or triplet II4. Date of birth 7-3 1946 Hour 12:45 P.M.7. No. of weeks pregnancy 19 1/2

## FATHER OF CHILD

8. Full name Simon Peter Hase9. Color W 10. Age at time of this birth 57 yrs.11. Usual occupation Stationary Fireman

## MOTHER OF CHILD

12. Full maiden name Mildred Louise Packard13. Color W 14. Age at time of this birth 38 yrs.15. Usual occupation Housewife16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 117. Did child die before labor? No During labor? No18. Pregnancy, complications of uterine bleeding19. Labor: (a) Complications of uterine bleeding  
two weeks prior to abortion (b) Induced? No20. (a) Was there an operation for delivery? No  
(Yes or No)(b) State all operations, if any None(c) Did child die before operation? NoDuring operation? No23. (a) cremation (b) Date thereof 7-3-46  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory.....

24. (a) Funeral director.....

(b) Address .....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes low lying placenta(b) Maternal causes None

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature H. S. Scally  
(Specify if M. D., midwife, or other)

Address .....

25. (a) July 15, 1946 (b) Esther Bowers  
(Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per.....

RECEIVED  
JUL 17 1946  
BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

07344 302  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
Hillcrest Nursing Home.  
How long in hospital or institution?..... 5 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1817 Virginia Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Neva Howe

## 3. (b) Social Security Number

No

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed  
6. (b) Name of husband or wife.....  
7. Birth date of deceased (mo., day, yr.) April 9, 1860 6. (c) If alive, give age..... years  
8. AGE: Years..... 86 Months..... 3 Days..... 3 If less than one day..... hrs. .... min.

9. Birthplace..... New York State  
(Town, county, and state)  
10. Usual occupation..... Retired  
11. Industry or business..... Unk.  
12. Name..... Charles Bunnell  
13. Birthplace..... Unk.  
14. Maiden name..... Elizabeth Cox  
15. Birthplace..... Phelps, N.Y.  
16. Informant..... Mrs. Betty Garrison  
Address..... Phelps, New York.

17. Burial Date thereof July 14, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory.....  
Location..... Phelps, N.Y.  
18. Funeral director..... Fred W. Kraiss  
Address..... Hagerstown,

19. July 13, 46 19 46 Charles Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... July 12 th 19 46 at 8:30  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/9/44 19..... to 7/12/46  
and that I last saw him/her alive on 6/27/46 19.....  
Immediate cause of death.....  
Myocardial infarction, arteriosclerosis  
Heart Disease  
DURATION.....  
Unknown  
Due to.....  
Due to.....  
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury..... Injured at work?

23. SIGNATURE..... L. H. Hornbaker M. D. or other  
Address..... 154 W. Mrs. Livingston St. Date signed 7/12/46  
Hagerstown, Md.

RECEIVED

JUL 16 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

07345

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Breathedsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 Mos.  
 Hospital, institution, or street address where death occurred:  
Md. State Reformatory for Males  
 How long in hospital or institution? 17 Mos

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
 City or town Mechanicsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_  
None

## 3. (a) FULL NAME

Stanley Johnson

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 19 1925

8. AGE: Years 21 Months 3 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Marys St. Marys Co. Md.  
 (Town, county, and state)

10. Usual occupation Truck Driver

## 11. Industry or business

FATHER 12. Name James Johnson  
 13. Birthplace St. Marys Md.  
 MOTHER 14. Maiden name Martha Johnson  
 15. Birthplace St. Marys Md.

16. Informant Records of Md. State Ref. for Males  
Breathedsville Md.  
 Address

17. Burial Date thereof 7/30/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Josephs Cemetery  
St. Marys County Md.  
 Location

18. Funeral director Andrew K. Coffman  
Hagerstown Md.  
 Address

19. July 28 1946 John H. Bast  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946 19\_\_\_\_ at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to July 28 1946  
 and that I last saw him alive on July 27 1946

## Immediate cause of death

Lobar pneumonia

## DURATION

27 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other

Address Hagerstown, Md. Date signed 7-28-46

RECEIVED

AUG 1 1946

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

07346

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 5 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Chewsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Smithsburg Route #3  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Blanche Gertrude Jones

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife John W. Jones6. (c) If alive, give age 89 years7. Birth date of deceased (mo., day, yr.) February 25, 18968. AGE: Years Months Days If less than one day  
50 5 6 --- hrs. --- min.9. Birthplace Friendsville Montgomery Co., Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name David Wakefield13. Birthplace Rockville Maryland14. Maiden name Mary Alice Teets15. Birthplace Rockville Md.16. Informant John W. JonesAddress Smithsburg R. #217. Burial Date thereof August 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Maryland19. Aug. 3 19 46 Charles Bowers  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 46 at 9:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 19 46 to July 31 19 46 and that I last saw her alive on July 31, 1946 19 46

Immediate cause of death

Pulmonary Embolism

DURATION

5 WeeksDue to Thrombophlebitis, Route of pelvic veins (Ext. Inc. Bk. 46) 3 Wks.Due to Pulmonary Infarct - Ruptured lung. 3 Wks.

(Include pregnancy, within 3 months of death)

Major findings of operations Wound uter., Ovary, etc. Date of op. June 27, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip Whelan M. D. or otherAddress 159 W. Washington St. Date signed 8/1/46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
AUG 6 1946  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 07347300

### 1. PLACE OF DEATH:

County Washington  
City or town Fairplay  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? About thirty years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Fairplay  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Sarah Ellen Jones

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Richard G. Jones  
8. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) April 12, 1871  
8. AGE: Years 75 Months 3 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

AM

2D. DATE OF DEATH July 9, 1946 at 09:55

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6, 1946 to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw \_\_\_\_\_ alive on July 6, 1946

Immediate cause of death Cerebral  
hemorrhage DURATION 2 weeks

Due to Cerebral arteriosclerosis?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Henry Alder M.D. M. D. or other \_\_\_\_\_

Address Sharpsburg, Md. Date signed July 9/46

9. Birthplace Near Bedington, W. Va.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Thomas H. Willard

13. Birthplace Near Charleston, W. Va.

14. Maiden name Harriet E. Buttes

15. Birthplace Near Cherry Run, Md.

16. Informant Mrs. William Berger

Address 1304 Park Rd. N.W.

Washington, D.C.

17. Burial Date thereof July 13, 1946

(Burial, cremation, or removal. Which?) \_\_\_\_\_ (month) (day) (year)

Cemetery or crematory Manor Cemetery

Location Near Tilghmantown, Maryland.

18. Funeral director Mrs. Edith V. Leaf

Address Williamsport, Maryland.

19. (Date rec'd by registrar) July 10 46 Registrar Boyer

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Prather

170

07348

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Months  
 Hospital, institution, or street address where death occurred:  
102 Cypress St.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 102 Cypress St.  
 (If rural, give LOCATION)  
 2. (a) if veteran, name war None

## 3. (a) FULL NAME

Mrs. Annie Martin Wood Kaetzal

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Lewis  
 7. Birth date of deceased (mo., day, yr.) January 4 1856  
 8. AGE: Years 90 Months 6 Days 8 If less than one day  
hrs. min.

9. Birthplace Smithsburg Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Adam Martin  
 13. Birthplace Smithsburg Md.  
 14. Maiden name Susan Oswald  
 15. Birthplace Chewsville Md.

16. Informant Karl N. Beard  
 Address Hagerstown Md.  
 17. Removal Date thereof 7/14/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Oak Hill Cemetery  
 Location Nyack New York  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 14, 1946 Blanch Powers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

A

2D. DATE OF DEATH July 12 1946 19 at 9 M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1936 19 to July 12 19 46  
 and that I last saw him alive on July 12 19 46

Immediate cause of death Cerebral hemorrhage DURATION 3 da  
intercerebral 30 yrs

Due to intercerebral  
 Due to  
 Other conditions

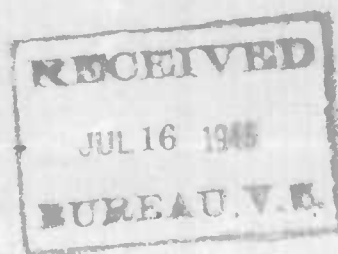
(Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE B. Prather M. D.  
 Address Hagerstown Md. Date signed 7/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1646

## CERTIFICATE OF DEATH

07349

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

Funkstown BridgeHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Funkstown  
 (If outside city or town limits, write RURAL and give nearest town)Street No. Beaver Creek Pike  
 (If rural, give LOCATION)2. (a) If veteran, name war... None

## 3. (a) FULL NAME

Mrs. Ada Harriett Kaylor

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife... Edward7. Birth date of deceased (mo., day, yr.) August 3 18818. AGE: Years Months Days If less than one day  
64 11 3 hrs. min.8. Birthplace... Hagerstown Wash. Co. Md.  
 (Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Own Home12. Name... John Powell13. Birthplace... Middleburg Pa.14. Maiden name... Lavinia Orris15. Birthplace... Middleburg Pa.16. Informant... Mrs. C.L. StoufferAddress... Funkstown Md.17. Burial Date thereof 7/9/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Rose Hill CemeteryLocation... Hagerstown Md.18. Funeral director... Andrew K. CoffmanAddress... Hagerstown Md.19. July 9 46 East Howerd  
 (Date rec'd by registrar) RegistrarMEDICAL CERTIFICATION E.O.S.T. A20. DATE OF DEATH... July 6 1946 About 11:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19... and that I last saw him... alive on 19...

Immediate cause of death... Suffocation by drowningDue to... Suffocation by drowningDue to... Suffocation by drowningOther conditions... Suffocation by drowning

(Include pregnancy within 3 months of death)

Major findings of operations... NoneAutopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... suicide Date of death... July 6 '46Where did injury occur... Funkstown Wash. Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where)... Artist's StudioMeans of injury... Drowning Injured at work? NoDEPUTY MEDICAL EXAMINER... S. Richard Wells WASH. CO., MD.23. SIGNATURE... Hagerstown, Md. M. D. O. 7/8/46Address... Hagerstown, Md. Date signed 7/8/46

59

1881

7/11/61

RECEIVED

JUL 11 1961

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

37  
FILE No. I 06 AUG 21 1946

# CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore 47d x

07350

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington  
City or town Rural Blue Ridge Summit Pa  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3308 Elgin Ave  
(If rural, give LOCATION) ✓

2(a) If veteran, name war

## 3. (a) FULL NAME

Cleveland J. Keating

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Catherine Myers

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1884 6. (c) If alive, give age 54 years

8. AGE: Years 61 Months 6 Days 8 It less than one day 10 hrs. 54 min.

9. Birthplace Baltimore Md  
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Sharp Inc.

12. Name Thomas Keating

13. Birthplace Md

14. Maiden name Clara Burkiss

15. Birthplace Md

16. Informant Catherine M Keating

Address 3308 Elgin Ave

17. Burial Date thereof 7/31/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore Md

18. Funeral director Walter J. Goss

Address 775 Church St. Weymouth, Pa.

19. July 28 1946  
(Date rec'd by registrar)

Walter J. Goss  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946 at 3:30 PM

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from June 1 1946 to July 28 1946  
and that I last saw him alive on 7-28-1946

Immediate cause of death Carcinoma of Lungs

Other conditions Carcinoma of Liver  
(Include pregnancy within 8 months of death)

Major findings of operations  Date of op.

Autopsy results   
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of   
Where did injury occur?  (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)   
Means of injury  Injured at work?

23. SIGNATURE H. B. Bridgman  
Blue Bridge Summit Pa  
Date signed 7/31/46

RECEIVED  
AUG 7 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Dr. Walter Wisherd 161

07351

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Chewsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 Years  
 Hospital, institution, or street address where death occurred:  
Chewsville Pike  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Chewsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Chewsville Pike  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Frank Hemsworth Kretsinger

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Emma  
 7. Birth date of deceased (mo., day, yr.) August 20 1872  
 6. (c) If alive, give age 71 years  
 8. AGE: Years 73 Months 10 Days 17 If less than one day  
 hrs. min.

9. Birthplace Beaver Creek Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Fruit Grower  
 11. Industry or business Own Farm  
 12. Name Ezra Kretsinger  
 13. Birthplace Beaver Creek Md.  
 14. Maiden name Susan Gantz  
 15. Birthplace Beaver Creek Md.

16. Informant Mrs. Emma Kretsinger  
 Address Chewsville Md.  
 17. Burial Date thereof 7/9/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mausoleum  
 Location Smithsburg Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 9 46 Booth/Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1946 19 46 at 4 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 45 to July - 7 19 46  
 and that I last saw him alive on July - 3 19 46  
 Immediate cause of death Cerebral Hemorrhage  
 DURATION 2 mos  
 Due to Quarantined  
 Due to Arteriosclerosis 4 years  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Walter H. Wisherd M. D. or other  
Waynes Bros. Pharm  
 Address Date signed 7/8/46



RECEIVED

JUL 11 1946

BUREAU V.B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7. weeks  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 7. weeks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Smithsburg Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

Fannie Mae Leathers

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife \_\_\_\_\_  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased Feb 7 - 1866  
8. AGE: Years 79 Months 9 Days 13 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Fred Co Md  
(Town, county, and state)  
10. Usual occupation Home Keeping  
11. Industry or business \_\_\_\_\_  
12. Name William Strope  
13. Birthplace Fred Co Md  
14. Maiden name Seraphine Manahan  
15. Birthplace Fred Co Md

16. Informant Elmer Law  
Address Smithsburg Md  
17. Burial Smithsburg Md  
(Burial, cremation, or removal? Watch?) Date thereof 7-12-1946  
(month) (day) (year)  
Cemetery or crematorium Smithsburg Md  
Location Smithsburg Md  
18. Funeral director Glenn H Hoover  
Address Smithsburg Md

19. July 10 46  
(Date rec'd by registrar) Registrar Phoebe Bowers

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1946 at 10:26 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him alive on July 9 1946  
Immediate cause of death Hypostatic pneumonia DURATION 3 day  
Due to fracture of neck of June 4  
1946  
Due to Accidental fall, stairs  
Slipped on steps  
Other conditions Myocarditis 10 yrs  
Artery 3 after 1000  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of May 23, 1946  
Where did injury occur? Smithsburg, Dist. 2, Washington, Maryland  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) at home  
Means of injury fall Injured at work?

23. SIGNATURE E. G. K. O'Brien M. D. or other  
7/9/46 Date 7/9/46  
Address Smithsburg Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Dr. W.D. Campbell 187

07352

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 1/2 hours

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 7 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Chestnut Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No. Harpers Ferry Road  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Anna May Lee

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 27, 1946

## 8. AGE:

Years

Months

Days

If less than one day

7 hrs. 30 min.9. Birthplace Hagerstown Washington Co. Md.  
(Town, county, and state)10. Usual occupation Infant11. Industry or business --

FATHER

12. Name Richard E. Lee13. Birthplace Elliot Ohio

MOTHER

14. Maiden name Catherine E. Kennedy15. Birthplace Hagerstown Maryland16. Informant Richard E. LeeAddress Harpers Ferry West Virginia R#417. Burial Date thereof 7/29/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 29, 1946 Chas. H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 46, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 27 19 46 to July 27 19 46  
and that I last saw him alive on July 27 19 46

Immediate cause of death

premature  
under 24 hrs.  
poorly developed

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.D. Campbell

M. D. or other

Address Date signed

RECEIVED  
JUL 31 1946  
BUREAU V. S.



RECEIVED  
JUL 19 1946  
FOREIGN A. R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07354

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 55 Years

Hospital, institution, or street address where death occurred:

795 Hamilton Blvd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 795 Hamilton Blvd.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Moses R. Lyon

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lena Lyon

## 7. Birth date of

deceased (mo., day, yr.)

Aug. 5, 1873

## 6. (c) If alive, give age

years

## 8. AGE:

Years

72

Months

10

Days

25

If less than one day

hrs.

min.

## 9. Birthplace

Russia

(Town, county, and state)

## 10. Usual occupation

11. Industry or business Retired Merchant

## FATHER

12. Name Samuel Lyon13. Birthplace Russia

## MOTHER

14. Maiden name Fredia Lazeik15. Birthplace Russia

## 16. Informant

Mrs. M. R. LyonAddress 795 Hamilton Blvd. Hagerstown Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof July 5, 1946

(month) (day) (year)

## Cemetery or crematory

Hebrew Cemetery

## Location

Hagerstown, Md.

## 18. Funeral director

Fred W. Kraiss

## Address

Hagerstown, Md.

## 19.

July 6, 1946  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1946 9:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 to Aug 3, 1946  
and that I last saw him alive on July 3, 1946

Immediate cause of death

DURATION

Cerebral hemorrhage12 hrs.

Due to

hypertension10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hagerstown, Md.M. D. 7.5.46  
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 9 1946

BUREAU V.S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15703

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 4 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Maugansville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Nursing Home  
(If rural, give LOCATION)2.(a) If veteran, name war -

## 3. (a) FULL NAME

James Clarence Martin

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife -6.(c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.)

June 30 1946

8. AGE:

Years

Months

Days

If less than one day

6

hrs.

min.

9. Birthplace Maugansville Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Infant11. Industry or business -FATHER  
MOTHER

12. Name

Wilbur Martin

13. Birthplace

Broadfording Md.

14. Maiden name

Flo Meyers

15. Birthplace

Greencastle Pa.

16. Informant

Wilbur Martin

Address

Hagerstown Md. R# 2

17.

Burial

Date thereof

7/7/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Grove Cemetery

Location

Cedar Grove Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

July 7, 1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1946 19 46 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-3 19 46 to 7-6 19 46and that I last saw h.i.m. alive on 7-6 19 46

Immediate cause of death

BronchopneumoniaGangrene ileum

Due to

Due to

Intestinal obstruction -  
congenital

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Intestinal obstructionDate of op. 7-4-46Autopsy results Gangrene ileum, Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

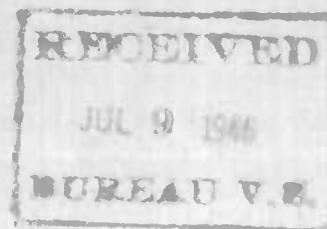
Means of injury Injured at work?

23. SIGNATURE Elizabeth L. Linn M. D. or otherAddress Hagerstown Md. Date signed 7-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15120

## CERTIFICATE OF DEATH

Reg. Dist. No. 07356 302

### 1. PLACE OF DEATH:

County... Washington  
City or town... Mangonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... MD County...  
City or town... Mangonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No...  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary W Martin  
4. Sex W 5. Color or race W 6. (a) Single, married, widowed, or divorced S.

### 3. (b) Social Security Number

### 6. (b) Name of husband or wife

6. (c) If alive, give age... years  
7. Birth date of deceased (mo., day, yr.) May 30 1864

8. AGE: Years 82 Months 1 Days 9 If less than one day... hrs. ... min.

9. Birthplace... Lancaster Pa  
(Town, county, and state)

10. Usual occupation... House Keeper

### 11. Industry or business

MOTHER FATHER  
12. Name... Abraham Martin  
13. Birthplace... Lancaster Co. Pa  
14. Maiden name... Barbara Wenger  
15. Birthplace... Lancaster Pa

16. Informant... Isaac Martin  
Address... Mangonsville Md.

17. (Burial, cremation, or removal) Which? B Date thereof July 11-1946  
(month) (day) (year)

Cemetery or crematory... Reiff Cemetery  
Location... Near Coopers Md

18. Funeral director... R E Minnich  
Address... Greencastle Pa.

19. July 9 19 46 Phyllis Bowser  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... 7/9 19 46 at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to 7/9 19 46 and that I last saw him alive on 7/8 19 46.

Immediate cause of death... Chronic Endocarditis  
Chronic Nephritis  
Arterio-Sclerosis  
DUE TO...  
DUE TO...  
Other conditions... ✓  
(Include pregnancy within 8 months of death)

Major findings of operations...  
Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide... ✓ Date of...  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE W. D. Miller  
Hagerstown Md.  
Address... Date signed 7/9 19 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 11 1945  
BUREAU VV

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
344 N. Cannon Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 344 N. Cannon Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles Clayton Mayhugh

## 3. (b) Social Security Number

214-09-7467

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Sue Mayhugh  
 7. Birth date of deceased (mo., day, yr.) Nov. 13, 1881  
 6. (c) If alive, give age ..... years  
 8. AGE: Years 64 Months 8 Days 12 If less than one day  
 ..... hrs. .... min.

9. Birthplace Franklin County, Pa.  
 (Town, county, and state)  
 10. Usual occupation Guard  
 11. Industry or business Fairchild Aircraft Corp.  
 12. Name Edward Mayhugh  
 13. Birthplace Franklin Co., Pa.  
 14. Maiden name Rebecca Gossard  
 15. Birthplace Franklin Co., Pa.

16. Informant Mrs. Sue Mayhugh  
 Address 344 N. Cannon Ave. - Hagerstown, Md.  
 17. Burial Beautiful View Cemetery Date thereof July 28, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Middleburg, Md.  
 Location

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. July 28, 1946 Blair H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1946 19..... at P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 15, 1946 to July 25, 1946  
 and that I last saw him alive on July 15, 1946

Immediate cause of death Coronary Occlusion DURATION 1/2 hr

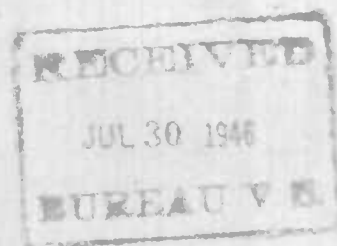
Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Ernest H. Pooler, M.D. M. D. or other  
 Address Hagerstown, Md. Date signed 7/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Dr. Kneisley

07358

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 Years  
 Hospital, institution, or street address where death occurred:  
Sharpsburg Pike  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown R. # 3  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Sharpsburg Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Harry Campbell McCubbin

## 3. (b) Social Security Number

705-10-6214

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Edna  
 6. (c) If alive, give age 62 years  
 7. Birth date of deceased (mo., day, yr.) September 17 1882

8. AGE: Years 63 Months 9 Days 17 If less than one day  
 hrs. min.

9. Birthplace Owings Mill Baltimore Co. Md.  
 (Town, county, and state)

10. Usual occupation W. M. R. R.

11. Industry or business Train Despatcher

FATHER 12. Name Joseph McCubbin

13. Birthplace Finksburg Md.

MOTHER 14. Maiden name Alice Fitch

15. Birthplace Finksburg Md.

16. Informant Mrs. Edna McCubbin

Address Hagerstown Md. R # 3

17. Burial Date thereof 7/6/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. July 6 19 46 Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1946 19 46 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 1, 1946 19 46 to July 4, 1946

and that I last saw him alive on July 4, 1946 19 46

Immediate cause of death  
Coronary occlusion

DURATION  
5 hours

Due to

Due to

Other conditions Chronic myocarditis with  
congestive failure  
 (Include pregnancy within 3 months of death)

3 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

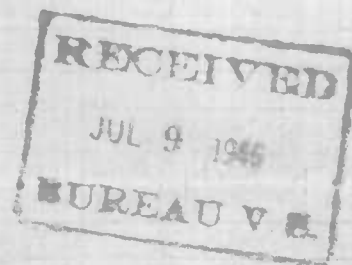
Means of injury Injured at work?

23. SIGNATURE B. B. Bowers M. D. or other

Address 148 W. Washington St. Date signed 7/6/46



here  
bring  
back





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 07359 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hillcrest Convalescent Home

How long in hospital or institution?

1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Frederick  
 City or town..... Middletown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Mrs. Cora Rensburg Michael

## 3.(b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

Charles W. Michael

7. Birth date of deceased (mo., day, yr.)

Oct 20, 1865

6.(c) If alive, give age.....

70 years

8. AGE:

Years

Months

Days

If less than one day

8094

hrs.

min.

9. Birthplace.....

Middletown Md  
(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER

12. Name.....

Lewis Rensburg

13. Birthplace.....

Middletown Md

MOTHER

14. Maiden name.....

Ann Brent

15. Birthplace.....

Middletown Md

16. Informant.....

Neoma Rensburg

Address.....

Middletown Md

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

July 27, 46  
(month) (day) (year)

Cemetery or crematory.....

Southern Cemetery

Location.....

Middletown Md

18. Funeral director.....

Gladhill Funeral Home

Address.....

Middletown, Md.

19.

(Date rec'd by registrar)

19.

7646

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 24 1946 at 7:15P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1946 to July 24 1946and that I last saw her alive on July 24, 1946 1946

Immediate cause of death.....

Coronary occlusion

DURATION

10 days

Due to.....

Due to.....

Other conditions..... Chronic myocarditis

Indef.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

B. B. Shively

M. D.

M. D. or other

Address 148 W. Washington St. Date signed 7/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 29 1945  
BUREAU U. S. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46 is especially important. Physicians: please write the causes of death clearly and legibly.

# Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

07473

161

## 1. PLACE OF DEATH

County WashingtonCity or town Clear Spring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred

Washington Co. 5 Days HospitalHow long in hospital or institution? 5 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Clear Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Lethian Miller

## 3.(b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed8.(b) Name of husband or wife Edward Miller

B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 12-18648. AGE: Years 82 Months 8 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington Co.  
(Town, county, and state)10. Usual occupation House work

11. Industry or business \_\_\_\_\_

12. Name John H. Miller13. Birthplace Washington Co.14. Maiden name Lethian Hauer15. Birthplace Washington Co.16. Informant Mrs Edgar LesherAddress Clear Spring Md17. Burial Date thereof July 14 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium St Pauls CemeteryLocation Near Clear Spring18. Funeral director Snyder - RowlandAddress Clear Spring, Md19. July 12 19 46 Clear Spring

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 46 at 9:55 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 46, to July 11 19 46and that I last saw him/her alive on July 10 19 46Immediate cause of death Acute Myocardial FailureDURATION 1 dayDue to Fractured Hip 6 daysDue to Accidental fall - sugarTripped over a rug

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 14 19 46Where did injury occur? Clear Spring, Washington Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At her homeMeans of injury Fall Injured at work? \_\_\_\_\_23. SIGNATURE David H. Brewer M.D.Address Clear Spring Md Date signed 7/14/46

M. D. or other \_\_\_\_\_

RECEIVED  
JUL 15 1946  
BUREAU V.R.

07360

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
330 North Cannon Ave  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 330 North Cannon Ave  
 (If rural, give LOCATION)  
None  
 2. (a) If veteran, name war...

## 3. (a) FULL NAME

Mrs. Emma Elizabeth Moler

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marvin R.  
 6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 29 1886

8. AGE: Years 60 Months 3 Days 18 If less than one day  
 hrs. min.

9. Birthplace Reid W. shington Co. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Claggett Lehman

13. Birthplace Star Town Md.

14. Maiden name Ida Fonk

15. Birthplace Leitersburg Md.

16. Informant Marvin R. Moler

Address Hagerstown Md.

17. Burial Date thereof 7/20/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. July 19 1946 Claggett Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1946 19... at 8:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19... to 19...  
 and that I last saw h... alive on 19...

Immediate cause of death... 19...

Duration

Asphyxiation by hanging

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op. ...

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7/17/46

Where did injury occur? Hagerstown Md. (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury hanged self Injured at work? No

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown, Md. WASH. CO., MD.

Date signed 7/17/46

MARGIN RESERVED FOR BINDING

I

3

9-45-15

VS A15

9-45-15

9-45-15

9-45-15

9-45-15

9-45-15

9-45-15

9-45-15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2

## CERTIFICATE OF DEATH

07361

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural - Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 or 15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Wilson  
(If outside city or town limits, write RURAL and give nearest town)Street No. On old Comococheague Creek road  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Mrs. Ora Barnhart Murray

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife William L. Murray7. Birth date of deceased (mo., day, yr.) Feb 16, 18698.(c) If alive, give age — years8. AGE: Years 77 Months 5 Days — If less than one day — hrs. — min.9. Birthplace Washington Co., Md.  
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business —12. Name Jacob Barnhart13. Birthplace —14. Maiden name Yallora Stine15. Birthplace Germany16. Informant Mrs. Bertha LayAddress Hancock, Md.17. Burial Date thereof July 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Presbyterian Church CemeteryLocation Warfordsburg Penna.18. Funeral director Charles R. BastAddress Hancock, Md.19. July 21 19 46 Gray M. L. Lott  
(Date registered by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1946 at 8:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 — to July 19, 1946and that I last saw him alive on July 18, 1946Immediate cause of death Myocardial Sclerosis

## DURATION

Due to Chronic Sclerosis 8 yrsDue to Chronic Sclerosis 10 yrsDue to — —Other conditions Langrene left leg 2 weeksCerebral Hemorrhage 1944

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE David P. Brewer M.D. M. D. or otherAddress Clear Spring Md. Date signed 7/21/46



RECEIVED

SEP 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred:

Washington County HomeHow long in hospital or institution? 35 Years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Washington County Home  
(If outside city or town limits, write RURAL and give nearest town)Street No. Hagerstown, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Benjamin Myers

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Rebecca Myers7. Birth date of deceased (mo., day, yr.) Oct. 21 1854

6. (c) If alive, give age ..... years

## 8. AGE:

Years

Months

Days

If less than one day

911010

hrs.

min.

9. Birthplace Clear Spring, Md.  
(Town, county, and state)10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name Joseph Myers13. Birthplace Maryland14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Emma. BrooksAddress Hagerstown, Md.17. Burial Date thereof Aug. 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland.19. Aug 3 19 46 Chas. H. Bowers  
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1946 8:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1st to July 31 19 1946  
and that I last saw him alive on July 31st 19 46

Immediate cause of death

Cerebral Hemorrhage  
Hemiplegia left

DURATION

1 mo.

Due to

Due to Arteriosclerosis10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest J. Proctor  
M. D. or other  
Address Hagerstown Md Date signed 8/2/46

REC'D

AUG 6 1946

BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

## CERTIFICATE OF DEATH

07363

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 Years  
 Hospital, institution, or street address where death occurred:  
342 N. Mulberry St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 342 N. Mulberry St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Bessie F. Palmer

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Palmer7. Birth date of deceased (mo., day, yr.) Aug. 18, 1884

8. AGE: Years 61 Months 10 Days 29 If less than one day  
 ...hrs. ...min.

9. Birthplace Welsh Run, Franklin Co., Pa.  
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name Lewis Pike13. Birthplace Franklin County, Pa.14. Maiden name Mary Jane Snyder15. Birthplace Welsh Run, Pa.16. Informant Mrs. Betris YoungAddress Hagerstown, Md.17. Burial Date thereof July 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beaver Creek CemeteryLocation Beaver Creek, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Maryland.19. July 19, 1946 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946 at 7:20 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19

Immediate cause of death

Vascular hypertension DURATION 10 yrsDue to diabetes mellitus 5 yrsDue to coronary occlusion 4 mo

Other conditions

acute ventricular fibrillation  
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells, M.D. M. D.Address Hagerstown, Md Date signed July 18 '46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

36

07364 346

1. PLACE OF DEATH:  
County..... Washington  
City or town..... Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 2 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... MD County..... Washington  
City or town..... Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME..... Elmer Melancthon Palmer 3. (b) Social Security Number..... 220-05-6751

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Sulu J. Warrenfeltz

7. Birth date of deceased (mo., day, yr.)..... Oct-15-1870 6. (c) If alive, give age..... years

8. AGE: Years..... 75 Months..... 9 Days..... 21 It less than one day..... hrs. .... min.

9. Birthplace..... Wolserill, Frederick Co  
(Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business.....

12. Name..... Uriah M. Palmer

13. Birthplace..... Fellsville MD

14. Maiden name..... Imkey M. Hess

15. Birthplace..... Wolfsville MD

16. Informant..... Mrs J. Clark Traver

Address..... Smithsburg MD

17. Burial..... Date thereof..... 7/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Smithsburg

Location..... Smithsburg

18. Funeral director..... Walter E. GAGE

Address..... 371 Church St. Waymire Pa

19. Date rec'd by registrar..... July 12 1946

Registrar..... Geo H. Ferguson

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 9 1946 at 11:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1946 to July 9 1946

and that I last saw him alive on July 9 1946

Immediate cause of death..... Cerebral Hemorrhage

Due to..... Arterio-Sclerosis

Due to.....

Other conditions..... Branching Cisterna

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... G. G. Kotler

Address..... Smithsburg Date signed..... 7/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 23 1946  
BUREAU V.R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1172)

## CERTIFICATE OF DEATH

Reg. Dist. No. 800

## 1. PLACE OF DEATH:

County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph William Poffenbarger

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertha Anna Poffenbarger6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) Dec. 29, 18778. AGE: Years 68 Months 6 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sharpsburg, Maryland.  
(Town, county, and state)10. Usual occupation Farmer (Retired)11. Industry or business Farm12. Name Otho Poffenbarger13. Birthplace Sharpsburg, Maryland14. Maiden name Elizabeth Welsh15. Birthplace Ireland16. Informant Mrs. Bertha Anna PoffenbargerAddress Sharpsburg, Maryland.17. Burial Date thereof July 10, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Maryland18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Maryland.19. July 10 1946 Clay Zysa  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1946, at 0730 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 1946, to July 7 1946and that I last saw him alive on July 7 1946Immediate cause of death Heart disease DURATION 2 weeksDue to probable peptic ulcer 6 mos.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter H. Shagly, M.D.Address Sharpsburg, Md. Date signed 7/9/46



RECEIVED  
AUG 3-1945  
BUREAU V.S.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore 940

# CERTIFICATE OF DEATH

Dr. Hirshman

07366

Reg. Dist. No. 302

<b>1. PLACE OF DEATH:</b> County: <u>Washington</u> City or town: <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>15 Years</u> Hospital, institution, or street address where death occurred: <u>19 South Foundry St.</u> How long in hospital or institution? <u>None</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State: <u>Maryland</u> County: <u>Washington</u> City or town: <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>19 South Foundry St.</u> (If rural, give LOCATION) <u>None</u> 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Charles Abram Rennecker</u>				<b>3. (b) Social Security Number</b> <u>219-05-2409</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Sadie V.</u>				<b>6. (c) If alive, give age</b> <u>57</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>December 16 1882</u>							
<b>8. AGE:</b> Years <u>63</u>		Months <u>6</u>		Days <u>15</u>		If less than one day _____ hrs. _____ min.	
<b>9. Birthplace</b> <u>Grind Stone Hill Franklin Co. Pa.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Machinist</u>							
<b>11. Industry or business</b> <u>Landis Machine Co.</u>							
MOTHER FATHER	<b>12. Name</b> <u>Abram Rennecker</u>						
	<b>13. Birthplace</b> <u>Grind Stone Hill Pa.</u>						
	<b>14. Maiden name</b> <u>Martha Rossman</u>						
	<b>15. Birthplace</b> <u>Germany</u>						
<b>16. Informant</b> <u>Mrs. Ruth Long</u> Address <u>Hagerstown Md.</u>							
<b>17. Burial</b> Date thereof <u>7/3/46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Grind Stone Hill Cemetery</u> <u>Grind Stone Hill Pa/</u> Location <b>18. Funeral director</b> <u>Andrew K. Coffman</u> Address <u>Hagerstown Md.</u>							
<b>19.</b> <u>July 3</u> 19 <u>46</u> (Date rec'd by registrar) Registrar <u>Chas. Bowers</u>							

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> <u>July 1 1946</u>	
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>June 25</u> 19 <u>46</u> to <u>July 1</u> 19 <u>46</u> and that I last saw him <u>alive</u> on <u>June 25</u> 19 <u>46</u> .	
<b>Immediate cause of death</b> <u>Coronary occlusion</u>	<b>DURATION</b> <u>15 Minutes</u>
<b>Due to</b> _____	
<b>Other conditions</b> _____	
(Include pregnancy within 3 months of death)	
<b>Major findings of operations</b> _____ Date of op. _____	
<b>Autopsy results</b> _____	
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.	
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:	
Accident, suicide, or homicide _____ Date of _____	
Where did injury occur? (City or town) _____ (County) _____ (State) _____	
Injured at home, farm, industry, public place (where?) _____	
Means of injury _____	Injured at work? _____
<b>23. SIGNATURE</b> <u>Chas. Bowers</u> M. D. or other _____ <u>15740 Washington St</u> Date signed <u>7/3/46</u>	

RECEIVED

JUL 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49-21 X

## CERTIFICATE OF DEATH

07367300  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
City or town Mondel, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 years  
Hospital, institution, or street address where death occurred:  
Mondel, Maryland  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Mondel  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Sharpsburg, Rt. #1  
(If rural, give LOCATION)  
2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary E. Richardson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Marshall Richardson  
6. (c) If alive, give age 59 years  
7. Birth date of deceased (mo., day, yr.) September 11, 1886  
8. AGE: Years 59 Months 9 Days 26 It less than one day  
hrs. min.

9. Birthplace Franklin County, Pa.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business

FATHER 12. Name E. L. Trace  
13. Birthplace Franklin County, Pa.  
MOTHER 14. Maiden name Clara Peters  
15. Birthplace Franklin County, Pa.

16. Informant Marshall Richardson  
Address Mondel, Maryland

17. Burial Date thereof 7-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Broadfording Cemetery  
Location Broadfording, Maryland

18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland

19. 7-8-46 Ed. J. Rogers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1946, at 1 A. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1946, to July 7 1946, and that I last saw him alive on July 5 1946.  
Immediate cause of death Carcinoma of left ovary  
Due to Diabetes  
Due to Hypertension  
Other conditions  
DURATION  
10 yrs  
10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE G. W. Rellan M.D.  
M. D. or other  
Address Boonsboro Date signed July 8, 1946

RECEIVED

AUG 3 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07368

168

Reg. Dist. No. 382

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hill Crest Rest HomeHow long in hospital or institution? 10 Days

## 3. (a) FULL NAME

Mary E. Ridenour

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## B. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Harry C. Ridenour

## 7. Birth date of deceased (mo., day, yr.)

May 13, 1885

S. (c) If alive, give age..... years

## 8. AGE:

Years

61

Months

1

Days

26

If less than one day

hrs.

min.

9. Birthplace..... Quincy, Franklin Co. Penna.  
(Town, county, and state)10. Usual occupation..... Home Duties

## 11. Industry or business

FATHER

12. Name..... Jeremiah Derr13. Birthplace..... Penna.

MOTHER

14. Maiden name..... Emma. Munemaker15. Birthplace..... Quincy, Penna.16. Informant..... H. Paul RidenourAddress..... Hagerstown, Md.17. Burial Date thereof..... July 12, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Rest Haven CemeteryLocation..... Hagerstown, Md.18. Funeral director..... Fred. W. KraussAddress..... Hagerstown, Md.19. July 12 1946 Registrar  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland WashingtonCity or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 25 Broadway

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 8 - 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 - 46 19..... to..... July 8 - 46 19.....and that I last saw him alive on..... July 8 - 46 19.....

Immediate cause of death.....

DURATION

Chn Myocarditis2 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

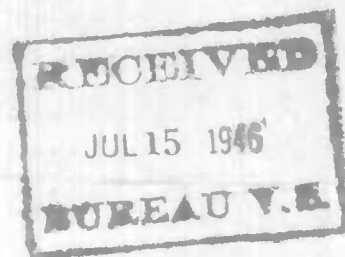
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed..... 7/12/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

33

Dr Kohler

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07369

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:  
 County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Ind County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Samuel I Pidenour

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 8. (b) Name of husband or wife Annie Stephy  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 23 1862  
 8. AGE: Years 83 Months 8 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace near Smithsburg Ind  
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name William Pidenour

13. Birthplace Ind

14. Maiden name Betsy Stevenson

15. Birthplace Ind

16. Informant Miss Lulu Pidenour

Address Smithsburg Ind

17. Burial Date thereof 7 5 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg Cemetery

Location Smithsburg Ind

18. Funeral director Walter H Groove

Address Waynesboro Pa

19. July 4 19 46 Geo W. [unclear]  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 46 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 46 to July 2 19 46 and that I last saw him alive on July 2 19 46

Immediate cause of death Profusely Embolic DURATION 5 mts

Due to Myocarditis 10-48

arterio Sclerosis 20 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

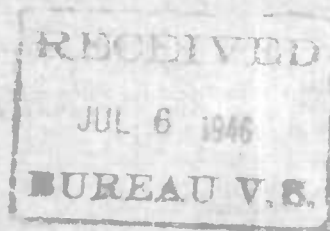
\_\_\_\_\_

23. SIGNATURE Y G Kohler

Address Smithsburg Date signed 7/3/46

30F12

Handle



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07370

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Mos.

Hospital, institution, or street address where death occurred:

Md. State Reformatory for MalesHow long in hospital or institution? 4 Mos

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1422 Paca St.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Henry Robinson

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Divorced6. (b) Name of husband or wife Jane  
6. (c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) August 7 19008. AGE: Years Months Days If less than one day  
45 11 19 hrs. min.9. Birthplace Baltimore City Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business ---12. Name Henry Robinson Sr.13. Birthplace Baltimore City Md.14. Maiden name Mary Robinson15. Birthplace Baltimore City Md.16. Informant Records of Md/ State Ref. for MalesAddress Breathedsville Md.17. Burial Date thereof 7/29/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Md. State Ref. CemeteryLocation Breathedsville Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 28, 46 John H. Bask  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 19 46 at 11 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 18 19 46 to July 26 19 46  
and that I last saw him alive on July 26 19 46Immediate cause of death Pulm. Tuberculosis

DURATION

3 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

X-ray results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or otherAddress Hagerstown, Md. Date signed 7-28-46

RECEIVED  
AUG 1 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Dr. wells

182

07371

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Hour  
 Hospital, institution, or street address where death occurred:  
Municipal Swimming Pool  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 723 South Potomac St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

William Newton Rohrer

## 3. (b) Social Security Number

219-12-0296

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Martha Ellen  
 1. Birth date of deceased (mo., day, yr.) March 10 1870  
 8. AGE: Years 76 Months 4 Days 11 If less than one day  
hrs. min.

9. Birthplace... Tilghmanton Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation... Ticket Taker  
 11. Industry or business... Mun. Swimming Pool

12. Name... William Rohrer  
 13. Birthplace... Rohrersville Md.  
 14. Maiden name... Susan Moats  
 15. Birthplace... Tilghmanton Md.

16. Informant... Mrs. Samuel Nunanaker  
 Address... Hagerstown Md.

17. Burial Date thereof 7/23/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Mountain View Cemetery  
 Location... Sharpsburg Md.

18. Funeral director... Andrew K. Coffman  
 Address... Hagerstown Md.

19. July 22 1946 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

EDT

20. DATE OF DEATH... July 21 1946 19... at 9:30A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19... to 19...  
 and that I last saw him... alive on 19...  
 Immediate cause of death...

Chr. myocarditis  
coronary occlusion  
3 d.  
 Due to...  
 Other conditions...

(Include pregnancy within 3 months of death)  
 Major findings of operations... No  
 Date of op...  
 Autopsy results... no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... no Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... J. R. Wells DEPUTY MEDICAL EXAMINER  
Hagerstown, Md. WASH. CO., MD.  
 Address... Date signed 7/22/46

RECEIVED  
JUL 24 1946  
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Wolfinger

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

07372

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH: *Washington*  
 County.....  
 City or town..... *Hagerstown #5*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *6 years*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... *Ind* County..... *Washington*  
 City or town..... *Hagerstown #5*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *near Ringgold*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Miss Frances Elizabeth Sheller*

## 3. (b) Social Security Number

4. Sex..... *Female* 5. Color or race..... *W* 6. (a) Single, married, widowed, or divorced..... *Single*

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *Oct 18 1853*

8. AGE: Years *92* Months *8* Days *14* If less than one day..... hrs. .... min.

9. Birthplace *Marion Penna*  
 (Town, county, and state)

10. Usual occupation..... *House work*

11. Industry or business.....

12. Name..... *David Sheller*13. Birthplace..... *Franklin Co Pa*14. Maiden name..... *Mary Huss*15. Birthplace..... *Franklin Co Pa*16. Informant..... *Mrs Sara Monon*Address..... *Marion Penna*

17. *Burial* Date thereof..... *7 5 1946*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Brown hill*Location..... *Franklin Co Penna*18. Funeral director..... *Walter G Grove*Address..... *Waynesboro Pa*

19. *July 5 1946* Registrar  
 (Date rec'd by registrar) local

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *July 2 1946* at *4 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*June 30 1946* to *July 2 1946*  
 and that I last saw her alive on *July 1 1946*

Immediate cause of death.....

*myocardial failure*Due to..... *Senility*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Walter L Wolfinger*

M. D. or other

Address..... *Waynesboro Pa* Date signed..... *5 July 1946*



RECEIVED  
JUL 6 1946  
BUREAU V R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-0)

07373

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Smithsburg md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Leo HospitalHow long in hospital or institution? 1. Day.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Smithsburg md  
(If outside city or town limits, write RURAL and give nearest town)Street No. - - - - -  
(If rural, give LOCATION)2. (a) If veteran, name war none

## 3. (a) FULL NAME

Philip Lee Smith

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

none

## 7. Birth date of deceased (mo., day, yr.)

7-15-19446. (c) If alive, give age - years

## 8. AGE:

Years

Months

Days

If less than one day

1917- hrs. - min.

## 9. Birthplace

Beaumont, Pa.  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

John L. Smith

## 12. Name

Beaumont, Pa.

## 13. Birthplace

Beaumont, Pa.

## 14. Maiden name

Eveline Geraldine Cullen

## 15. Birthplace

Beaumont, Pa.

## 16. Informant

John L. Smith

## Address

Smithsburg md

## 17. Burial

Smithsburg md Date thereof 7-8-1946  
(Burial, cremation, or removal, which?) (month) (day) (year)

## Cemetery or crematory

Smithsburg md

## Location

Smithsburg md

## 18. Funeral director

Geo. B. Hoover

## Address

Smithsburg md

## 19. Date rec'd by registrar

July 2 1946 Registrar Thos. Bowers

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1946, at P. 2 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to July 2 1946and that I last saw him alive on July 2 1946

## Immediate cause of death

Hypoglycemic Coma

## DURATION

1 day

## Due to

Acute Yellow Atrophy

## Due to

of the liver

## Other conditions

Diabetes Mellitus

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. July 2

## Autopsy results

Acute Yellow Atrophy liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of July 2

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

John L. Smith M. D. or otherAddress 24 W. Pratt St. Date signed 7/2/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU V.S.

546

32

2411 N. Charles St., Baltimore 124-B

07374

303

# CERTIFICATE OF DEATH

Reg. Diet. No.

<b>1. PLACE OF DEATH:</b> County <u>Washington</u> City or town <u>Clear Spring Rural</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>40 years</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Clear Spring Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION)  2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>John. William Snyder</u>				<b>3. (b) Social Security Number</b> <u>None</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>B. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>B. (b) Name of husband or wife</b> <u>Mary Snyder</u>				<b>B. (c) If alive, give age</b> <u>65</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Oct. 6 1878</u>							
<b>8. AGE:</b> Years <u>67</u>		Months <u>9</u>		Days <u>11</u>		It less than one day .....hrs. ....min.	
<b>9. Birthplace</b> <u>Washington Co.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Laborer</u>							
<b>11. Industry or business</b>							
<b>MOTHER</b>	<b>12. Name</b> <u>William Snyder</u>			<b>13. Birthplace</b> <u>Washington Co</u>			
	<b>14. Maiden name</b> <u>Mary McCarthy</u>			<b>15. Birthplace</b> <u>Washington Co</u>			
	<b>16. Informant</b> <u>Mrs. Mary Snyder</u>						
	<b>Address</b> <u>Clear Spring Md Rural</u>						
<b>17. Burial</b> <u>Burial</u> Date thereof <u>July 20 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Blairs Valley Cemetery</u> Location <u>Blairs Valley</u>							
<b>18. Funeral director</b> <u>Snyder - Bowland</u> Address <u>Clear Spring, Md</u>							
<b>19. July 19 1946</b> <u>Joseph W. Murray</u> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>July 17, 1946</u> at <u>5:50 P.M.</u>							
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan 42</u> to <u>July 17, 1946</u> and that I last saw him alive on <u>July 16, 1946</u>							
<b>Immediate cause of death</b> <u>Chr. Hypertrophic Cirrhosis of Liver</u>							
<b>DURATION</b> <u>6 yrs</u>							
<b>Due to</b>							
<b>Due to</b>							
<b>Other conditions</b>							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b>							
Date of op.							
<b>Autopsy results</b>							
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:							
Accident, suicide, or homicide. Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
<b>23. SIGNATURE</b> <u>David R. Brewer M.D.</u> M. D. or other Address <u>Clear Spring Md</u> Date signed <u>7/17/46</u>							

RECEIVED

SEP 16 1946

BUREAU V M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07375-306

1. PLACE OF DEATH  
 County... Washington  
 City or town... Cavetown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... md County... Washington  
 City or town... Cavetown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2(a) If veteran, name war...

## 3. (a) FULL NAME

Anna Mary Spessard

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1861 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 84 Months 6 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cavetown Md.  
 (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business

12. Name Samuel H. Spessard13. Birthplace Washington Co. Md.14. Maiden name Susan R. Hawkins15. Birthplace Washington Co. Md.16. Informant C. P. SpessardAddress Cavetown Md.

17. Burial Date thereof 7/5/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cavetown Reformed CemeteryLocation Cavetown Md.18. Funeral director Walter J. SporeAddress 37 Church St. Waynesboro, Pa19. July 5 1946 Geo. W. Ferguson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1946 to July 4 1946  
 and that I last saw him alive on July 4 1946

Immediate cause of death Coronary Thrombosis

DURATION

3 daysDue to Heart - Sclerosis

Due to

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

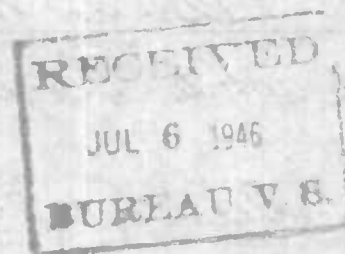
Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of Injury

23. SIGNATURE G. G. K. OckerAddress San Antonio Date signed 7/8/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

Dr. Victor Miller 174

07376

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 Years  
 Hospital, institution, or street address where death occurred:  
227 Frederick St.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 227 Frederick St.  
 (If rural, give LOCATION)  
None  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

William Cornelius Stouffer

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower6. (b) Name of husband or wife Emma Catherine7. Birth date of deceased (mo., day, yr.) October 9 18618. AGE: Years Months Days If less than one day  
84 9 5 .....hrs. ....min.9. Birthplace Hagerstown Wash. Co. Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name John M. Stouffer13. Birthplace Akron Ohio14. Maiden name Isabelle Mace15. Birthplace Hagerstown Md.16. Informant Clarence M. StoufferAddress Hagerstown Md.17. Burial Date thereof 7/16/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 16 19 46 Phas H. Boward  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1946 19..... at 10.3021. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7/11 19 46 to 7/14 19 46  
and that I last saw him alive on 7/13 19 46

Immediate cause of death

chronic endocarditis  
nephritis  
arterio-sclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

DR. VICTOR S. MILLER

M. D. or other

Address 101 W. WASHINGTON ST.Date signed 7/15 1946

RECEIVED  
JUL 18 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-0)

CERTIFICATE OF DEATH

07377

Reg. Dist. No. 307

1. PLACE OF DEATH:

County.....Washington  
City or town.....(Rural) Sandy Hook  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....24 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....Maryland County.....Washington  
City or town.....(Rural) Sandy Hook  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....None

3.(a) FULL NAME

Eva Gertrude Waters

3.(b) Social Security Number

None

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Single

6.(b) Name of husband or wife.....None

7. Birth date of deceased (mo., day, yr.).....October 29, 1919 6.(c) If alive, give age..... years

8. AGE: Years.....26 Months.....8 Days.....24 If less than one day..... hrs. .... min.

9. Birthplace.....Summit Point, Jefferson Co., W. Va.  
(Town, county, and state)

10. Usual occupation.....Housework

11. Industry or business.....Own Home

12. Name.....Charles Owen Waters

13. Birthplace.....Loudoun County, Virginia

14. Maiden name.....Luna Blanche Webb

15. Birthplace.....Loudoun County, Virginia

16. Informant.....Mrs. Blanche Waters

Address.....Box 120, R.F.D., Knoxville, Md.

17. Burial.....Brownsville Cemetery

(Burial, cremation, or removal. Which?) Date thereof.....July 26, 1946  
(month) (day) (year)

Cemetery or crematory.....Brownsville, Md.

Location.....Brownsville, Md.

18. Funeral director.....Melvin T. Stinner

Address.....Charles Town, W. Va.

19. July 24 1946 Dornelina H. Deane  
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 23, 1946 at.....6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....July 23 1946 to.....July 23 1946

and that I last saw her alive on.....July 23 1946

Immediate cause of death.....Coronary Heart Failure DURATION.....4 mo

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....W. H. Carpenter M. D.

Address.....Lowellville, Va. Date signed.....7/24/46

RECEIVED  
AUG 5 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

## CERTIFICATE OF DEATH

Dr. wells

07378

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Taylor's LandingHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 4  
(If outside city or town limits, write RURAL and give nearest town)Street No. Reid  
(If rural, give LOCATION)2. (a) If veteran, name war World War # 2 [★]

## 3. (a) FULL NAME

Melvin Harry Weber

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lorraine

7. Birth date of

deceased (mo., day, yr.)

November 17 1923

8. AGE:

Years

Months

Days

If less than one day

22720

hrs.

min.

6. (c) If alive, give age 21 years9. Birthplace Leitersburg Wash. Co. Md.  
(Town, county, and state)10. Usual occupation Cabinet Maker11. Industry or business Colonial hardwood Flooring Co.12. Name Harry E. Weber13. Birthplace Reid Md.14. Maiden name Rhoda Strite15. Birthplace Leitersburg Md.16. Informant Mrs. Lorraine WeberAddress Hagerstown Md. R # 417. Burial Date thereof 7/10/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Millers Mennonite ChurchLocation near Leitersburg Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 23 1946  
(Date rec'd by registrar)Ellis B. Bux  
Registrar

## 3. (b) Social Security Number

219-14-9541

## MEDICAL CERTIFICATION

July 7 194620. DATE OF DEATH 19 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him 19 to 19Immediate cause of death Suffocation by drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/7/46Where did injury occur 3 mi. above Taylor's Landing Wash. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Potomac RiverMeans of injury Drowned Injured at work? No

DEPUTY MEDICAL EXAMINER

WASH. CO., MD.

M. D. Dr. Wells23. SIGNATURE Dr. WellsAddress Hagerstown, Md. Date signed 7/7/46

RECEIVED

AUG 3 1946

BUREAU V.S.

82  
5561  
9/1/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472 X

## CERTIFICATE OF DEATH

Reg. Dist. No. 07379  
302

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred:

Hill Crest Nursing HomeHow long in hospital or institution? 7 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 179 Summit Ave

(If rural, give LOCATION)

None

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles M. Welty

## 3. (b) Social Security Number

705-10-8636

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna M6. (c) If alive, give age 50 years

7. Birth date of

deceased (mo., day, yr.) December 16 1895

8. AGE:

Years

50

Months

7

Days

0

If less than one day

hrs.

min.

9. Birthplace

Norfolk Norfolk Co. Va.

(Town, county, and state)

10. Usual occupation

Cabinet Maker

11. Industry or business

Statton Furn. Co.

FATHER

12. Name

Charles M. Welty

13. Birthplace

Pittsburg Pa.

MOTHER

14. Maiden name

No Record

15. Birthplace

No Record

16. Informant

Mrs. Anna Welty

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/21/46

(month) (day) (year)

Cemetery or crematory

Green Hill Cemetery

Location

Waynesboro Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19. 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1946 19 46 at 4 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 May 1946 to 18 July 1946  
and that I last saw him alive on 19

Immediate cause of death:

Carcinoma pulmonary,  
left upper lobe

DURATION

From  
the day I was  
born  
2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

As above - inoperable  
Date of op. June 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

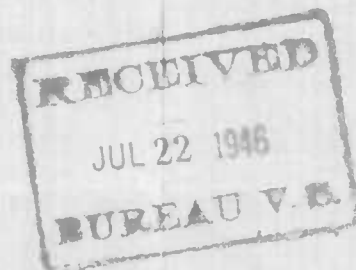
23. SIGNATURE

W. D. Layman M.D.

M. D. or other

Address 100 Professional Bldg Date signed 19 July 46  
Hagerstown, Md.





Reg. Dist. No. 502

1. PLACE OF DEATH:

County.....Washington.....  
City or town.....Hagerstown.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....Life.....  
Hospital, institution, or street address where death occurred:  
.....Sharpsburg Pike, Hagerstown R.F.D.....  
How long in hospital or institution?.....

**3. (a) FULL NAME**

George W. Wiley

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Rural Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Sharpsburg Pike  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

None

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed	
6.(b) Name of husband or wife..... Mary E. Wiley			
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age ..... years	
November 13, 1857			
8. AGE:	Years	Months	Days
	88	7	29
			If less than one day
			.....hr. ....min.

9. Birthplace..... Washington County, Md.  
(Town, county, and state)

10. Usual occupation.....Retired

### 11. Industry or business

12. Name ..... Harim Wiley

**FAT** 13. Birthplace Maryland

HER	4 Maiden name	Sarah Hornbraker
-----	---------------	------------------

15. Birthplace	Maryland
----------------	----------

16. Informant Mrs. Pearl Waldecker  
Address Sharpsburg Pike, Hagerstown, Md

17. Burial Date thereof July 15, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....St. Pauls Cemetery.

Location Western Pike route# 40

18. Funeral director.....Fred W. Kraiss

Address Hagerstown, Maryland.

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 12, 1946 ..... 19..... 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1943 to July 12 1946 and that I last saw him alive on June 26 1946

Immediate cause of death.....	DURATION
-------------------------------	----------

Chronic myo carditis 34yr.  
Arterio sclerotic heart disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... none

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... 17A2 ..... Date of .....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Mean of injury 20 Injured at work? ☐

23. SIGNATURE.....

transmission (nd) 7/13/16

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 17 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Eugene Wilhelm

## 3.(b) Social Security Number

213-12-7314

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Lena May Startzman Wilhelm6.(c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) Oct. 7, 1875

8. AGE: Years Months Days If less than one day

7098

hrs. min.

9. Birthplace Sharpsburg, Wash., Maryland  
(Town, county, and state)10. Usual occupation Labor farm, roads.

11. Industry or business

12. Name John Baker Wilhelm13. Birthplace Washington county Maryland.14. Maiden name Anna Zellia Suter15. Birthplace Keedysville, Maryland16. Informant Lena May WilhelmAddress Sharpsburg, Maryland17. Burial Date thereof July 28, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Maryland.Edith V. Leaf

18. Funeral director

Address Williamsport, Maryland.19. July 27, 46 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1946 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25, 1946 to July 25, 1946and that I last saw him alive on July 25, 1946Immediate cause of death Urinary

DURATION

Due to Chronic Cardiac - UrinaryDue to Chronic diseaseOther conditions Probable Cancer

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. SharpsburgAddress Sharpsburg, Md. Date signed 7/26/46

M. D. or other

RECEIVED

AUG 3 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-a)

## CERTIFICATE OF DEATH

Dr. Campbell  
Dr. Hauver07382  
Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 2 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 18 West Antietam St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. Anna Kershner Willard

## 3. (b) Social Security Number

232-01-9290

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife George  
6. (c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) September 4 1914 19178. AGE: Years Months Days If less than one day  
28 10 8 hrs. min.9. Birthplace Marlowe Berkeley Co. W. Va.  
(Town, county, and state)10. Usual occupation Stenographer11. Industry or business Board of Education12. Name Daniel G. Kershner13. Birthplace Marlowe W. Va.14. Maiden name Anna Reid15. Birthplace Williamsport Md.16. Informant George WillardAddress Hagerstown Md.17. Burial Date thereof 7/14/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 14, 1946 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 19. 6.15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1946 to July 12 1946  
and that I last saw him alive on July 12 1946 19. 19Immediate cause of death Acute Myocardial Infarction  
Reaction following blood transfusion  
DURATION 7  
1/2 h.

Due to

Due to

Other conditions Frequent Frank breech  
Cesarean Section  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Enlarged spleen - no surgical complications found  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

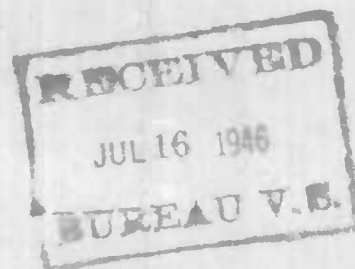
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. CampbellAddress Hagerstown Md. M. D. or otherDate signed July 13/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 07383 305

1. PLACE OF DEATH:  
 County Washington  
 City or town Breathedsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Months  
 Hospital, institution, or street address where death occurred:  
Md. State Reformatory for Males  
 How long in hospital or institution? 3 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County -  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 123 South Caroline St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None ✓

## 3. (a) FULL NAME

Edward Willis

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife -  
 7. Birth date of deceased (mo., day, yr.) June 18 1918  
 8. AGE: Years 28 Months 0 Days 26 If less than one day  
 hrs. min.

9. Birthplace Cecil County Md.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business --  
 FATHER 12. Name He was a ward of the Henry  
 13. Birthplace Watson Childrens aid  
 MOTHER 14. Maiden name Society since Birth.  
 15. Birthplace --

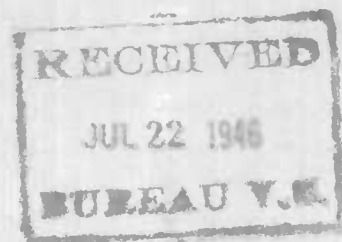
16. Informant Md. State Reformatory Files  
 Address Breathedsville Md.  
 17. Burial Date thereof July 17, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Md. State Reformatory Cem.  
Breathedsville, Maryland.  
 Location  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md  
 19. July 16, 1946 John H. Bask  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1946 19 46 at 11 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 46 to July 13 19 46  
 and that I last saw him alive on July 12 19 46  
 Immediate cause of death Pulm. Tuberculosis  
 DURATION 3 weeks  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Robert P. Conrad, M.D. M. D. or other  
Hagerstown Md Address Date signed 7-15-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (225) X

## CERTIFICATE OF DEATH

Dr. Beachley

07384

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred:  
Washington county hospital  
 How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 426 Virginia Ave  
 (If rural, give LOCATION)  
 2. (c) If veteran, name war World War # 1 (★)

## 3. (a) FULL NAME

Dr. Harley Broadwell Wood

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Nelle  
 7. Birth date of deceased (mo., day, yr.) October 27 1888 6. (c) If alive, give age 50 years  
 8. AGE: Years 57 Months 6 Days 25 If less than one day  
hrs. min.

9. Birthplace Diesterich Effingham Co. Ill  
 (Town, county, and state)  
 10. Usual occupation Veterinarian  
 11. Industry or business U.S. Bureau of Animal Husbandry

FATHER  
 12. Name David L. Wood  
 13. Birthplace Rushville Ind.  
 MOTHER  
 14. Maiden name Maggie Parks  
 15. Birthplace Effingham Ill

16. Informant Mrs. Nelle Wood  
 Address Hagerstown Md.

17. Removal Date thereof 7/23/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Windsor Cemetery  
 Location Windsor Ill.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 23, 1946 Beachley  
 (Date rec'd by registrar) Registrar

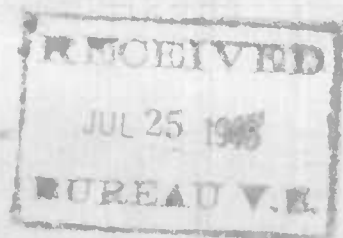
## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946 19 46, at 3 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1946 to July 22, 1946  
 and that I last saw him alive on July 22, 1946  
 Immediate cause of death Carcinoma of Bladder bys.

Due to Carcinoma of Bladder bys.  
 Due to Carcinoma of Bladder bys.  
 Other conditions Carcinoma of Bladder bys.  
 (Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Bladder bys.  
 Date of op. July 22, 1946  
 Autopsy results Carcinoma of Bladder bys.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Carcinoma of Bladder bys. Date of July 22, 1946  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Carcinoma of Bladder bys. Injured at work?  
 23. SIGNATURE Dr. Beachley  
 Address Hagerstown Md. Date signed July 23, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

07385

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:  
Washington County Hospital  
2 weeks

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1042 The Terrace  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Rebecca Yeager

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 10, 1884

8. AGE: Years 61 Months 9 Days 26 If less than one day  
 hrs. min.

9. Birthplace Bear Gap, Pa.  
 (Town, county, and state)

10. Usual occupation Housework11. Industry or business Own Home12. Name Simon S. Yeager13. Birthplace Northumberland Co. Pa.14. Maiden name Mahala J. Adams15. Birthplace Bear Gap, Pa.16. Informant Dr. W. Howard YeagerAddress Hagerstown, Maryland17. Burial Date thereof 7-9-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Irish Valley CemeteryLocation Shamokin, Pa.18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. July 6, 1946 Chas. H. Bowers

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1946 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24, 1946 to July 6, 1946and that I last saw him alive on July 5, 1946

Immediate cause of death

DURATION

Carcinoma with metastasesDue to generalized 1.5 mos.Primary carcinoma of breastDue to Duration: 15 months approx.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. L. Campbell M.D.Address Hagerstown Md Date signed 7/6/46

RECEIVED

JUL 9 1946

BUREAU V.S.